

trial. Country-specific unit costs data were obtained from national sources. Costs are reported in 2007 euro. **RESULTS:** Iodixanol is cost-effective compared to iohexol with both lower costs and better effects related to fewer ADRs. For Germany, Italy, Spain, Sweden, and UK, respectively, the mean per patient cost differences due to the reduction in ADRs were €444, €431, €574, €859, and €753. **CONCLUSIONS:** Iodixanol results in fewer ADRs and resulted in lower ADR costs per patient for this high risk patient population across the five European countries.

PCV55

PHARMACOECONOMIC EVALUATION OF TREATMENT WITH PROCORALAN® PREPARATION COMPARED TO INVASIVE TREATMENT

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OBJECTIVES: To determine economic impact of Procoralan® therapy in stable angina patients as compared to invasive PCI/CABG therapy. **METHODS:** A cost-minimisation, probabilistic model performed from a third party payer perspective in Poland. Costs calculations were based on the National Health Fund rates. Invasive therapy cost was assumed to be a weighted average of PCI/CABG, according to Poland-specific proportions. Clinical assumptions and risk profiles were derived from the Euro Heart Survey. The economic impact was calculated for the patients not qualified for invasive therapy or maintenance therapy with beta-blocker due to contraindications or intolerance. Both one-way (drug cost) and multi-way (revascularisation risk, reimbursement level) sensitivity analyses were performed. **RESULTS:** The incremental costs per patient per year were as follows: €747.82–743.34 for Procoralan® 5 mg/7.5 mg therapy respectively; € 3879.88 for CABG, €2265.88 for PCI. The reduction in payer's expenditure in the range of €1918.32–1922.81 per patient per year was demonstrated as a result of the application of Procoralan® 5 mg/7.5 mg therapy instead of the invasive therapy. The obtained result applies to the case of the whole Procoralan® price borne by the payer (100% reimbursement). In the case of 70% and 50% reimbursement rates savings amounted to €2112.09–2115.23 and €2248.05–2250.20 depending on dose of the drug. The sensitivity analyses results showed that change of the Procoralan® treatment cost (+/–50%), wide range of changes in the risk of a secondary revascularisation and the reimbursement level did not influence the ultimate interpretation of the results. **CONCLUSIONS:** Third party payer's benefits related to Procoralan® may apply to all patients suffering from angina symptoms having contraindications or intolerance to beta-blocker. The greatest savings concern patients not qualified for invasive therapy as no alternative treatment is effective in this group, but in all scenarios the Procoralan® therapy was proven to be cost-saving for public payer.

PCV56

AN ECONOMIC ANALYSIS OF INDUCTION OF LABOR AND EXPECTANT MANAGEMENT IN WOMEN WITH PREGNANCY-INDUCED HYPERTENSION OR PREECLAMPSIA AT TERM (HYPITAT TRIAL)

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OBJECTIVES: To compare the costs of induction of labor with the costs of an expectant management strategy in women with

pregnancy-induced hypertension (PIH) or preeclampsia (PE) at term. **METHODS:** The Hypertension and Preeclampsia Intervention Trial At Term (HYPITAT) was a multicentre randomized controlled clinical trial conducted in The Netherlands between October 2005 and April 2008. Women diagnosed with PIH or PE at ≥ 36 weeks of gestation were randomly allocated to either induction of labor or expectant management. The study showed that induction of labor reduced both maternal complications as well as the caesarean section rate as compared to expectant management. The economic analysis was performed from a societal perspective. Resource utilization was documented by specific items in the Case Report Forms (CRF) and additional questionnaires. For most medical unit costs, we used estimates provided by the financial and economic departments of two participating hospitals (one academic and one general hospital). For non-medical costs and primary care costs Dutch standardized prices were used. Sensitivity analyses were performed to explore the impact of different assumptions and cost estimates on the results of the costs analysis. **RESULTS:** Data of 756 women were analyzed. Mean costs per patient were €5400 for induction and €6025 for expectant management (difference €625). This 10% difference predominantly originated in the ante partum period: per patient €977 for induction versus €1929 for expectant management. Comparable costs were found for delivery (€761 versus €790 per patient). No substantial differences were found in the post partum period. **CONCLUSIONS:** In women with PIH or PE at term, costs associated with induction of labor are considerably lower as compared to expectant management. This cost reduction is mainly due to differences in resource utilization in the ante partum period.

PCV57

ESTIMATING THE NUMBER AND COST OF CARDIOVASCULAR EVENTS AVOIDED BY TREATING TO ALTERNATIVE LDL-C TARGETS: IS LOWER BETTER?

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OBJECTIVES: To estimate the number and cost of cardiovascular (CV) events avoided over five years by treating with statins to alternative low-density lipoprotein cholesterol (LDL-C) targets of <3.0 mmol/L and <2.0 mmol/L, based on 1000 patients with established cardiovascular disease (CVD) or diabetes from an NHS perspective. **METHODS:** Proportional effects per mmol/L LDL-C reduction for non-fatal myocardial infarction (MI), coronary revascularisation and stroke were taken from a meta-analysis of 14 randomised controlled trials of statin therapy. Absolute risk reductions (ARR) between control and treatment arms were calculated. Baseline LDL-C value of 3.6 mmol/L (SD 1.27) was taken from the Health Survey for England 2003 and 5000 LDL-C values ≥ 3.0 mmol/L and ≥ 2.0 mmol/L were randomly generated from this distribution giving mean baseline LDL-C values of 4.24 mmol/L and 3.86 mmol/L respectively. Absolute LDL-C reductions needed to meet the alternative targets were calculated and ARR in CV event incidence applied. The % reduction in CV events for 1000 patients was used to estimate number of CV events avoided; costs of events avoided were calculated using the National Tariff 2007–08. **RESULTS:** ARR between control and treatment arms was 1.8%, 1.8% and 0.6% for MI, coronary revascularisation and stroke respectively. Absolute reduction required to meet the LDL-C target of <3.0 mmol/L was 1.24 mmol/L resulting in 51 CV events avoided (22 MIs; 22 CABG/PTCAs; 7 strokes), with a total cost saving of £220,714 (MI = £70,158; CABG/PTCA = £130,368; stroke = £20,188). The 1.86 mmol/L required to meet the LDL-C target <2.0 mmol/L resulted in the 77 CV events avoided